# The GLP-1 Triage Aid

*When a patient qualifies under more than one indication, which pathway do you prescribe under?*

## 1 Assess the patient

*tick what applies*

### Obesity ☐

**Cohort I:** BMI ≥40 **AND** ≥4 qualifying comorbidities[1,2].

**Cohort II (from April 2026):** BMI 35 to 39.9 **AND** ≥4 qualifying comorbidities[3].

*Qualifying comorbidities: T2DM, hypertension, dyslipidaemia, OSA, established CVD[3]. Cohort III (BMI ≥40 AND ≥3 comorbidities) opens 2027 to 2028[3].*

### Type 2 diabetes ☐

All must apply:

• Triple therapy (metformin + 2 OADs) ineffective, not tolerated, or contraindicated[5]

**AND** • BMI ≥35 with obesity-related problem (≥32.5 for South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean background)[5]

*NG28 Feb 2026 widened access: T2DM **AND** established CVD, or early-onset T2DM (dx <40), or co-existing obesity[4].*

### Established CVD ☐

Both must apply:

• Previous MI **OR** previous stroke **OR** symptomatic PAD[6]

**AND** • BMI ≥27[6]

*T2DM and obesity are **not** required for this indication[6].*

## 2 Choose the pathway

*one prescription, one indication*

| OB | T2DM | CVD | PRESCRIBE UNDER | WHY THIS PATHWAY |
|---|---|---|---|---|
| ✓ | ⊗ | ⊗ | OBESITY | *Only indication available. Tirzepatide via ICB-commissioned pathway[1,2,3]* |
| ⊗ | ✓ | ⊗ | T2DM | *Glycaemic indication. GP prescription on FP10. Any GLP-1 RA per NG28[4,5]* |
| ⊗ | ⊗ | ✓ | CV RISK | *Semaglutide 2.4 mg weekly only. Adjunct to standard CV care[6]* |
| ✓ | ✓ | ⊗ | T2DM | *Prescribe under T2DM, not obesity. Reasons: GP prescription on FP10 (no ICB commissioning gate), weight loss is already a required continuation criterion under TA924, and broader agent choice. Document glycaemic management as the primary clinical rationale[4,5]* |
| ⊗ | ✓ | ✓ | T2DM | *Prescribe under T2DM. Per NG28 (Feb 2026), subcutaneous semaglutide titrated to a maximum of 1 mg weekly is the preferred GLP-1 RA in the established ASCVD cohort. This captures CV benefit within the T2DM prescription[4]* |
| ✓ | ⊗ | ✓ | CV RISK | *Prescribe under CV risk. Semaglutide 2.4 mg weekly is licensed for **both** CV risk reduction and obesity, and uses GP prescription on FP10 rather than the ICB obesity pathway[6]* |
| ✓ | ✓ | ✓ | T2DM | ***Default:** prescribe under T2DM with subcutaneous semaglutide titrated to maximum 1 mg weekly (NG28 preferred agent for ASCVD).* ***Switch to CV pathway** (semaglutide 2.4 mg weekly) **only if both**: CV risk reduction is the primary clinical goal **AND** glycaemia is already well controlled on existing therapy[4,6]* |

## 3 Prescribe and review

*pathway-specific facts*

### OBESITY

**AGENT**

Tirzepatide[2]

**FUNDING**

ICB-commissioned via local pathway[3]

**REVIEW AT 6 MONTHS**

Stop if weight loss from baseline is <5% at the highest tolerated dose[2]

### TYPE 2 DIABETES

**AGENT**

Any GLP-1 RA per NG28. If established ASCVD: subcutaneous semaglutide titrated to maximum 1 mg weekly is preferred[4]

**FUNDING**

GP prescription on FP10[5]

**REVIEW AT 6 MONTHS**

Continue **only if both** are met: HbA1c reduction ≥11 mmol/mol from baseline **AND** weight loss ≥3% from baseline[5]

### CV RISK REDUCTION

**AGENT**

Semaglutide 2.4 mg weekly. No other GLP-1 RA is licensed for this indication[6]

**FUNDING**

GP prescription on FP10. ICBs must fund within 90 days of TA publication (7 May 2026)[6]

**REVIEW**

No mandated stopping criterion. Review as adjunct to standard CV care[6]

## ! Mandatory safety checks before any pathway

*— 01 —*
**Contraception**
Tirzepatide only. Add barrier contraception **or** switch to non-oral method for 4 weeks after start **and** for 4 weeks after every dose increase. Applies to combined pill and POP[7]

*— 02 —*
**Oral HRT**
Review oral HRT in any patient starting any GLP-1 RA. Transdermal HRT is not affected[8]

*— 03 —*
**Private Rx notification**
On receiving notification of a private GLP-1 RA prescription, review interactions immediately. Do not defer to next annual review[9]

*— 04 —*
**Baseline records**
Before first prescription, record: weight, BMI, HbA1c (if T2DM), cardiovascular status[1,4,6]

# Worked Examples

*Four patients who qualify under more than one indication*

### CASE 1
58 year old man

**CLINICAL FEATURES**
- T2DM, HbA1c 64 mmol/mol
- On metformin **and** gliclazide
- BMI 36
- No established CVD

**PATHWAY CHOICE**

***T2DM (NG28 / TA924)***

Glycaemic indication is primary. Eligible for any GLP-1 RA per NG28. Continuation at 6 months requires **both** HbA1c reduction ≥11 mmol/mol from baseline **and** weight loss ≥3% from baseline[4,5]

### CASE 2
62 year old woman

**CLINICAL FEATURES**
- Previous MI (2023)
- BMI 31
- No T2DM (HbA1c 38 mmol/mol)
- On standard secondary prevention

**PATHWAY CHOICE**

***CV risk reduction***

Established CVD is the only indication she meets. Prescribe semaglutide 2.4 mg weekly as an adjunct to standard CV care. No mandated stopping criterion[6]

### CASE 3
54 year old man

**CLINICAL FEATURES**
- T2DM, HbA1c 58 mmol/mol on metformin
- BMI 41
- Previous stroke 18 months ago

**PATHWAY CHOICE**

***T2DM (with ASCVD preference)***

Qualifies under all three indications. Default to T2DM pathway with subcutaneous semaglutide titrated to maximum 1 mg weekly (NG28 Feb 2026 preferred agent for established ASCVD). One prescription captures glycaemic and CV benefit[4]

### CASE 4
47 year old woman

**CLINICAL FEATURES**
- BMI 42
- 4 qualifying comorbidities: hypertension, OSA, dyslipidaemia, T2DM
- No established CVD
- On combined oral contraceptive

**PATHWAY CHOICE**

***T2DM (NG28 / TA924)***

Qualifies for both obesity and T2DM. Prefer T2DM pathway: GP prescription, no ICB commissioning gate, weight loss already required as continuation criterion. **If tirzepatide** is chosen, add barrier contraception for 4 weeks after start **and** after every dose increase[4,5,7]

## References


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